

## Disabled Dependent Child Certification

### **Completing the Disabled Dependent Child Certification**

Completion of this certification is required for dependents that are coming upon the limiting age and need benefits to continue due to a physical or mental disability. To determine if your dependent qualifies for the Disabled Dependent Benefit, completion of this form by the employee and treating medical provider is required.

### **Instructions**

1. **Employee Statement Pages:** Sections I, II, III, and IV to be completed in their entirety by the employee. **Employee** is required to sign and date in Section IV. Employee Confirmation, Signature and Date.
2. Employee to provide an Active/Current copy of the "order/s" (*guardianship, conservatorship, court order, divorce decree*) employee has in place for the dependent if circled in Section II, Dependent Information and/or an Active/Current copy of the SSDI/SSI Benefit Statement if "Yes" was circled in Section III, Question 5.
3. Employee to provide a copy of the proof of prior coverage documents, **IE**, 'YES' was circled in Section III, Question 2 - "Did the dependent have a loss of coverage?"
4. **Medical Provider Statement Page:** To be completed in its entirety by the treating medical provider. **Treating medical provider** is required to confirm, sign and date.
5. Confirm all pages of the certification form have been completed in their entirety **AND** make a copy for your files before returning the form. (*omission of any information required will cause a delay in the processing of your request*)
6. Return all pages of the fully completed certification form and any additional documents to UnitedHealthcare at the email address or fax number shown below:

#### **Dependent Disability Dept.**

Email: disabled\_dep\_@uhc.com

or

Fax: 844-236-0933

Upon completion of the review process, you and/or your employer group will receive a letter advising of the review determination and coverage dates if applicable. Please allow up to 30 business days for review completion.

\*For any additional questions regarding your dependent child's eligibility benefits, please contact your employer's Human Resources Department for further assistance.\*



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E-mail: Disabled\_dep\_@uhc.com

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**Employee's Statement** Employee to complete Sections I, II, III & IV. Omitted information will cause delays.

### Section I. Employee Information

Group Number      Group Name

PRINT Name: (First, Middle, Last)

**Marital Status**     Never Married     Married     Divorced     Widowed     Legally Separated

Date of Birth      Member/Subscriber ID#      Relationship to Dependent      Phone: (Including Area Code)

Current Address(es) (Street, City, State, Zip Code)

Physical:

Mailing:

Email:

### Section II. Dependent Information

Refer to your Member Handbook for who qualifies as an eligible dependent.

Check **all applicable** orders in place by Employee regarding Dependent. If selected, **submit an Active/Current copy** of each with this form.

Guardianship     Conservatorship     Court Order     Divorce Decree

PRINT Name: (First, Middle, Last)

Date of Birth

**Marital Status**     Never Married     Married     Divorced     Widowed     Legally Separated

Does the Dependent reside in your household?      If **NO**, provide reason for different residing address than employee below.

Currently Resides at: (Street, City, State, Zip Code)

Physical:

Mailing:

### Section III. Financial and Dependent Employment Information

For Employees with a New Employer:

1. Was dependent covered under your prior Employer's Insurance Plan?

1a. If **YES**, provide Coverage dates.      From:      To:

1b. If **NO**, please explain.

2. Did the dependent have a loss of coverage?

2a. If **YES**, Submit a copy / proof of prior coverage AND answer coverage questions below:

Prior Insurance Carrier:

Subscriber's name:

Group Name:

Coverage dates:      From:      To:

3. Does employee provide more than 50% of the dependent's support & maintenance\*?

\*For example: food, medicine/prescriptions, utility, housing, etc.

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### Section III. Financial and Dependent Employment Information (Continued)

4. On what date was the dependent last claimed on your Federal Personal Income Tax Return? Date Last Claimed:

4a. Provide further explanation below.

5. Does dependent receive SSDI/SSI benefits?

If Yes: Amount per Month \$

5a. If YES, Submit a copy of current SSDI/SSI Benefit Statement.

6. Is dependent currently working?

6a. If dependent is NOT currently working, Date Last Employed:

6b. If dependent is currently working, Gross Monthly Income (before taxes) \$

6c. Is dependent's current position with employer eligible for health insurance?

6c-1. If answered YES, above in 6c, Is dependent carrying "own" health insurance?

6c-1a. If answered NO, above in 6c-1, provide explanation as to why dependent is not carrying "own" coverage.

6d. Provide Name and address of dependent's current employer below: (Street, City, State, Zip Code)

7. Is dependent currently a student in post-secondary schooling?

If Yes:

7a. If NO, what was the highest grade/level of schooling completed?

Enrolled:

Grade/Level:

School type:

8. Does dependent hold a valid drivers license?

9. Provide any further Explanations/Additional Information: (attach additional pages if needed)

### Section IV. Employee Confirmation, Signature and Date

I confirm I have completed the Employee's Statement in it's entirety. I know it is a crime to fill out this form with information I know is false or leave out information I know is important.

Employee Signature: \_\_\_\_\_

Date:

**For processing purposes, Employee's Statement and Medical Provider Statement MUST be submitted together.**



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**THIS PAGE IS TO BE COMPLETED IN FULL BY THE DEPENDENT'S TREATING MEDICAL PROVIDER ONLY.**

**Medical Provider Statement**

(Any fee for the completion of this statement is to be paid by the employee.)  
Answer all questions below. Omitted information will cause delays.

Patient's Name: (First, Middle, Last)

Patient's Date of Birth

1. What is the primary disabling diagnosis?

2. Age diagnosed with Primary Disabling Diagnosis?  From Birth  From \_\_\_\_\_ Years of Age

3. The patient is presently: (Check all applicable)  Ambulatory **Confined To:**  Bed  House  Hospital  Wheelchair

4. What are the physical/mental/functional limitations related to the primary disabling diagnosis?

5. Are there any other diagnoses currently being treated?

If Yes, please list below:

6. Is patient currently able to work?

If Yes:

7. Is patient currently able to be self-supportive [does not need financial help from others]?

7a. Is patient currently physically able to care for self?

8. Will patient be capable of self-support in the future?

If Yes, as of What Date:

9. If you answered NO to Questions 6-8 above. Please explain below. (Check all applicable)

Intellectual/Developmental Disability  Physical Handicap  Mental Handicap  Other (Explain below)

Documents Attached. Current written documentation or medical records within the last three (3) months.

I confirm I have completed the Medical Provider Statement in its entirety. I know it is a crime to fill out this form with information I know is false or to leave out information I know is important.

Medical Provider Signature:

Date:

PRINT Medical Provider Name, Address (Street, City, State, Zip Code)

Phone: (Including Area Code)

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